

THE SECRET TO DRUG TAPERS IS TIMING, DOSING, AND ACCURATE ALARMS AND RECORD KEEPING.

1) Reducing the dose based on the current dose level is the correct thing to do. The issue then becomes what percent to drop by and how long was the current dose maintained at that level. I dropped every week. That worked for me on hydrocodone. This might not work well for someone else. Or someone else might be able to drop every 5 or days.

I started out dropping by 5%. In research studies we can set a value for testing “significant” effects. 10% isn’t as conservative as 5%. Some one who is hypersensitive will definitely notice a change at 10% but it will be less likely at 5%. If you’ve noted repeated nausea and other withdrawal effects then the 2 variables you can change are the percent dosage drop or the time interval between drops. If you keep the drops to once every week it can make tracking a little easier. But if you change the drop to 5% and continue to note WD effects, even if intermittent, then it would be wise to increase the interval between drops. Simply doubling the weeks is conservative. If you note no more WD effects then stick to a 2 week interval for at least 2 months to establish that you can do dosage drops without suffering. This will be 4 total dose drops over that period and 4 chances to note if it works.

Once you’ve established a percent drop and interval that work with out any discomfort you can try decreasing the interval to optimize the time that it takes to get off of the opiates completely. If you do, then try making the interval every 11 days before a drop. This is just shy of halfway between 7 days and 14 days. If you get sick, then you should go back to either 14 days or between 11 and 14. This is a marathon, not a sprint. You have time to dial in what works best. This should create stability across the vast majority of your taper. If at any point you wind up sick again, it should be very moderate and it will give you the heads up that you need to adjust the interval or percent drop again (presuming the measuring of dose is consistently accurate, and that you have not done any thing to increase sensitivity such as take something like Naltrexone).

Calculating the daily dose: The graphs I posted were the total daily dosage. What I would do is use an alarm on my smartphone called “alarm clock extreme”. When my total daily dose was 30mg, I would assume 16 hours are awake, and 8 are asleep (this was never consistent), and I would divide the 16 by the half-life of hydrocodone (4hrs). That would give me 4 doses per day, at 4 hours apart. So $30/4=7.5$ mg per dose. You can do 8mg first thing when you wake, then 7mg, 3rd dose could be 7mg and the bed time dose would be 8mg. You can play with this a little, but the point is, you’re creating a highly stable quantity of painkiller in your system the entire time that you’re awake, which will reduce or eliminate pain that occurs as a result of not timing the doses well. This stability will also make noting any WD effects during a dosage or interval change much easier. The stability doing this is even more effective than the extended release opiates which I found to be garbage as they would release too

much. They tend to spike the blood more than this method, but this method isn't convenient for most people.

Given that you're on oxycodone, you should use the same methods for eventually transitioning that the benzodiazepine tapers use. Some one using a strong benzo would taper down and eventually get to a level where they would switch from the strong benzo, to valium which would be weaker, but it has a long half life which makes transitions and tapering smoother. So I would consider getting to an equivalent of oxycodone with 30mg of hydrocodone. That should be 20mg of oxycodone. $20 \times 1.5 = 30$.

Once on the 30mg of hydrocodone, you continue the same techniques with the interval and the dose drop. The transition from oxycodone to hydrocodone will probably have some mild discomfort, but given all of the stabilizing of the drug in the blood stream by dosing on the half-life through the day, and the interval and dosage drop the discomfort should be mild. The hydrocodone dose could be increased by a few milligrams as needed, but this establishes a different starting point for the hydrocodone. So rather than starting at 30mg, maybe it's 32 or 34mg. That's what you do daily for the entire new interval on hydrocodone until you do your dosage drop.

Oxycodone half-life: For immediate release it appears to be about 3.2 hours. You can go by this exactly or drop it to 3 hours, or push it to 3.5 hours, but don't change it much because dosing by the half-life requires staying close to this value to maintain stable blood plasma levels.

How to prep doses with accuracy: All opiates are water soluble. The cutting, filler, and binding agents aren't always soluble. The acetaminophen (a highly toxic substance to the liver which almost got pulled from shelves in 2009 if not for the deep pharma pockets) is not water soluble. So, we can create accurate doses for the taper by using distilled water, and not tap water, to put the known pill dose into a known water quantity. A 30 mg oxycodone pill put into 300 milliliters of water can be made into 3 doses at 10mg each, in 100 milliliters of water. Before we worry about the divisions the overall process is this: toss 1 pill into a known quantity of water. Let it sit in the fridge until it breaks down. Stir it. If it's all powder it's good to go. Filter this through 2 coffee filters into another glass. Let this sit and filter in the fridge. Cold water allows more selectivity for the opiates while fillers precipitate better. Once filtered pour the whole thing into a dedicated measuring cup. I preferred using a 250ml clear pyrex with a pouring spout.

So what will a day of dosing 30mg oxycodone by the half life look like? 3.2hr half-life, 16 hours awake / 3.2 hr = 5 doses per day at 6mg per dose. One at bed time, one at waking, 3 more spread between.

Let's assume bedtime is 12am. Set a dose alarm for 12am.

Wake at 8am.

Calculate the doses between 8am to 12am with even spacing.

16 hours between the 1st and 5th doses. So $16 / (3 \text{ (remaining doses)} + 1) = 4 \text{ hours between doses.}$

1st dose: 8am

2nd dose: 12pm

3rd dose: 4pm

4th dose: 8pm

5th dose: 12am

The 4 hours apart isn't right on the half-life but that's okay. From experience this was never an issue for me. If it seems to be an issue for you, then increase the number of doses in a day, while at the same time, each dose has to be decreased to keep your total daily dose at the current level you're at. Maybe rather than 5 doses at 6mg per dose in a day, 6 doses is smoother at 5mg each dose.

Record keeping: This is indispensable. A new physician that I started seeing when I was 1.5 years into my taper looked at the graphs I had created from my records and said he didn't want us to get lost in the details. As a peer reviewed published brain research scientist I know better. The worlds of research scientists and physicians mostly overlap on topic, but rarely by methods. Many physicians have gotten used to using the catch phrase "evidence based medicine" while not seeming to grasp what constitutes evidence. The daily dosing logs that I used along with daily totals that I used for my graphs are all evidence based procedure.

Getting to the point: Use manila folders for annual data logs. Use a blank printer sheet. Record the following:

Date:

Time: drug and dosage used

Notes: usually you can skip this, but if you note positive or negative issues then write them so you know if you can adjust your timing or dosing.

Example:

05/25/2024 (at the end of the day write the total here for easy reference to enter into excel)

12am- Oxycodone 6mg

8am- Oxycodone 6mg

12pm- Oxycodone 6mg

4pm- Oxycodone 6mg

8pm- Oxycodone 6mg

05/26/2024

12am- Oxycodone 6mg

8am- Oxycodone 6mg

12pm- Oxycodone 6mg

4pm- Oxycodone 6mg

8pm- Oxycodone 6mg

repeat ad infinitum

Use the front and back, then get a new sheet. Log all the totals and dates into excel for graphing. Then archive the paper in your manila folder and file away. These records are gold for tapering off of addictive substances. These methods are superior to any thing else out there that doesn't go by this approach. It creates an efficient and gentle taper.

I'll get to your other questions later. Feel free to ask for clarifications in what I've posted above. It's 4am here and I might not have been clear on some things. The method above allows for cutting doses all the way down to low low levels with accuracy and it will make it a piece of cake to jump off around 1-3mgs after you've been stable at those doses for a while. And the jump off doesn't have to be complete cold turkey. Just keep 1mg doses available to take as any withdrawal symptoms come. But if you taper down to these levels the WD effects will be minimal compared to higher dose WD effects. The plant kratom can be used to transition to off of opiates and then taper down on the kratom if need be. If interested ask because there is a rough opiate conversion for the kratom effect that myself and others on forums have agreed upon, including the apparent 3-3.5hr half life for kratom. Epsom salt soaks are excellent during these last months to reduce cramping effects. Cannabis can help with any headaches. But these tapers structured this way really do create an almost ideal absence of withdrawal. Some thing few doctors will do for patients and certainly not without charging many many thousands of dollars.